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Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS

High-level meeting on HIV/AIDS

Discussion paper for the round table on prevention to be convened by the United Nations Population Fund, the United Nations Educational, Scientific and Cultural Organization and the United Nations Office on Drugs and Crime

Summary

The present paper is aimed at stimulating discussions in the round table and should be read in conjunction with the forthcoming report of the Secretary-General on progress towards implementation of the Declaration of Commitment on HIV/AIDS.

A summary of the discussions, which are expected to be lively, open and interactive, will be conveyed to the High-level Plenary Meeting of the sixtieth session of the General Assembly in September 2005 so that it may undertake a comprehensive review of the progress made in the fulfilment of the commitments contained in the United Nations Millennium Declaration, including the internationally agreed development goals, and of the progress made in the integrated and coordinated implementation and follow-up to the outcomes of the major United Nations conferences and summits in the economic, social and related fields.

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1. Over 5 million new infections a year attest that collective world action to abate the HIV/AIDS epidemic has been insufficient. While prevention has long been heralded as the mainstay of the response, globally, fewer than one in five persons has access to basic HIV prevention programmes.[1] Large scale implementation of effective prevention remains hampered by social, cultural and leadership reluctance to deal with issues of sex, sexuality and high-risk behaviours together with the continued preponderance of poverty, gender inequality and lack of respect for the universality of human rights that fuel the epidemic. It is critical that efforts focus on AIDS as both an emergency and a long-term development issue, thus acting simultaneously on individual behavioural change and on wider social, cultural and economic change.

I. Linking sexual and reproductive health and HIV/AIDS

2. With sexual transmission the source of over 75 per cent of HIV infections, sexual and reproductive health services is a clear strategic entry point for maximizing the impact of HIV prevention efforts. Recent reports by the United Nations Millennium Project[2] take these linkages further, supporting conclusions that ensuring access to sexual and reproductive health information and services, including voluntary family planning, is essential for achieving the Millennium Development Goals[3] and that gender equality, essential in combating HIV, cannot be achieved without guaranteeing the reproductive rights of women and girls. Task Force 5 and its Working Group on HIV/AIDS of the Millennium Project also recommended that Governments incorporate universal access to reproductive and sexual health services as an integral part of their response to AIDS.[4]

3. In June 2004, a high-level global consultation reached similar conclusions, codified in the New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health, which emphasizes that sexual and reproductive health and HIV/AIDS initiatives must be mutually reinforcing as HIV, AIDS, and sexual and reproductive ill-health are driven by many common root causes, including gender inequality, poverty and social marginalization of the most vulnerable populations. Strong linkages between sexual and reproductive health and HIV/AIDS will result in more relevant and cost-effective programmes with greater impact, utilizing existing infrastructure for delivering maternal health, management of sexually transmitted infections, family planning and community-based outreach.

II. Prevention of mother-to-child transmission

4. Similarly the Glion Call to Action on Family Planning and HIV/AIDS in Women and Children (May 2004) focuses on preventing HIV among women and children, and linking family planning with prevention of mother-to-child transmission. Access to sexual and reproductive health services, including primary prevention in women and prevention of unintended pregnancies in women living with HIV, could decrease infection in children by 35 to 45 per cent in some countries.[5] Thus, universal access to reproductive health[6] is critical.

III. Women

5. The AIDS epidemic has insidiously taken a toll on women and adolescent girls, who account for nearly 50 per cent of all people living with HIV worldwide.[7] Bearing the brunt of the epidemic's impact, they are most often the caregivers for the sick, the most likely to lose their income and school opportunities and the ones who often confront stigma and discrimination and who suffer from underlying issues such as unequal property and inheritance rights and poor livelihood opportunities, which increase their vulnerabilities. Young women are particularly hard hit, representing over 60 per cent of all 15 to 24-year-olds living with HIV.

6. To reverse this impact, broad-scale action must be taken in countries to ensure: (a) that adolescent girls and women have the knowledge and means to prevent HIV infection; (b) equal and universal access to treatment; (c) support for home-based caregivers of AIDS patients and orphans; (d) promotion of girls' primary and secondary education and women's literacy; (e) promotion of zero tolerance for all forms of violence against women and girls; and (f) promotion and protection of the human rights of women and girls. Engaging civil society and other partners, such as the Global Coalition on Women and AIDS, a broad-based coalition aiming to stimulate concrete actions and lessen the devastating impact of AIDS on women and girls, must continue.

IV. Young people

7. The goals and targets of the twenty-sixth special session of the General Assembly provide a focus for national efforts to prevent HIV infections among young people by enabling them to adopt attitudes and behaviours that decrease their risk of infection and by ensuring that the environments in which they live, including social values and norms, support and do not undermine young people's ability to protect themselves from HIV. It is a major challenge to reach the over one billion adolescents now entering sexual maturity with the information, education, and health services they urgently need to protect themselves from HIV. The importance of such protection is even more urgent since, in many countries, large numbers of young people become sexually active while in their teens. Too often, however, young people are overlooked or discriminated against, and services are inaccessible or legally withheld until it is too late. Despite all the risks young people face, the information, education and services provided to them are woefully inadequate and engagement of key sectors such as education is often poor. With an estimated 5,000 to 6,000 young people becoming infected daily, in some regions constituting a significant percentage of high-risk populations, the needs of young people must be given the highest priority.

8. Education is a crucial and central element for enabling people to reduce both the risk of HIV infection and vulnerability to HIV/AIDS. Statistics show that the attainment of higher levels of education translates into the adoption of safer sexual behaviours (including deferred onset) and reduced vulnerability to HIV infection and other sexually transmitted infections, particularly for young girls. Yet universal primary education remains an illusive goal and the inclusion of HIV/AIDS in school curriculum does not guarantee that it will be taught. Commitments from the World Education Forum, held in Dakar in 2000, as well as targets contained in the Millennium Development Goals must be met.

9. In May 2004, a global consultation between the Joint United Nations Programme on HIV/AIDS (UNAIDS), research institutions, policy makers, programmers and funders reviewed the existing evidence base for interventions to achieve the global goals relating to HIV and young people. Interventions were allocated to "Steady", "Ready", "Go" categories. From the preliminary analysis, core interventions included: (a) skills-based sexual health education in schools, provided that the specified quality criteria for effective programmes are maintained; (b) youth-friendly health services offering core interventions for the prevention, diagnosis and treatment of sexually transmitted infections and HIV/AIDS; (c) interventions to prevent HIV transmission through unsafe drug injecting practices, and services targeted to other vulnerable groups at high risk; and (d) mass media interventions that are modeled on those media interventions that have demonstrable effectiveness and a dose-response effect. Conclusions confirmed that no single intervention can address the high HIV infection rates among young people. Young people are not a homogenous group and clearly require a range of interventions that address the diverse contexts in which they live, learn and earn.

V. Vulnerable populations

10. Individuals and groups that engage in high risk behaviour often experience heightened vulnerability due to marginalization, stigma and discrimination and economic and legal disempowerment. To prevent, halt and reverse epidemics among these groups requires interventions that both increase their access to prevention and care information and services and that address the root causes of their vulnerability.

11. One of the most contentious issues is that of HIV prevention among the 13.2 million injecting drug users worldwide. Government leaders must acknowledge their presence and risk of infection. HIV spreads rapidly among injecting drug users through the sharing of injecting equipment, compounded by poor access to drug dependence treatment and HIV prevention services. Their sexual partners can also become infected through unsafe sexual behaviour and their newborn children are frequently HIV-infected. In addition, drug injection along with tattooing and skin piercing, unsafe sexual behaviour and sexual violence create a high-risk environment for the 30 million who pass through prison in any given year.

12. Pilot projects are not the answer. Interventions are needed on a large scale to reach the majority of these populations and their families. Different government sectors (for example, health, justice, interior, police, education, finance and development planning) need to collaborate in a multidisciplinary team, including civil society organizations, to deliver needed services.

VI. Commodity security

13. In accordance with paragraph 52 of the Declaration of Commitment on HIV/AIDS, a wide range of prevention programmes should be made available yet major shortfalls remain for many elements. Condom programming, an integral component of HIV prevention strategies that include informed, responsible and safer sexual behaviour through abstinence, delayed age of onset of sexual activity, reduced number of sex partners and condom use, is one example. Critical messages need to be acknowledged and acted upon, including: (a) condoms are the single

most efficient available technology to reduce the sexual transmission of HIV and other sexually transmitted infections; (b) male and female condoms must be made readily available universally, either free or at low cost, and promoted in ways that help overcome social and personal obstacles to their use; (c) the complex gender and cultural obstacles to ensuring HIV prevention education and effective condom use must be overcome; (d) condoms play a decisive role in HIV prevention efforts in many countries especially those with concentrated epidemics and have also encouraged safer sexual behaviour more generally; and (e) increased access to voluntary counseling and testing and to antiretroviral treatment create the need and opportunity for accelerated condom promotion. In addition, the availability of sterile injecting equipment for injecting drug users in the context of comprehensive drug demand reduction can contribute significantly to reduce the rate of HIV transmission.

VII. World of work

14. The workplace is an excellent place to introduce HIV prevention programmes. Programmes reach employees, their families and communities and other key stakeholders, providing information on both occupational and personal risk reduction and prevention as well as for forging vital links between different sections of the population and between different interest groups. The workplace offers an important forum for: encouraging the elimination of stigma and discrimination; using different approaches to improve HIV prevention through practical, sustainable and effective interventions that result in changes in attitudes and personal behaviours; and facilitating and supporting these changes through initiatives that reach workers and their families.

15. Practical measures must be undertaken to ensure the success and coordination of workplace programmes, including: implementation of national and international strategies; infrastructure development; regulatory frameworks; technical capacity and support; media communications; mobilization of stakeholders (including young people), organizations and resources.

VIII. Emergencies

16. People in emergency situations, especially refugee populations, have a range of needs that are important for survival, health and well-being. As traditional supports collapse, the danger of HIV transmission increases. Desperate for food and shelter, resident populations and those who have been displaced can be forced to adopt risky behavioural practices. Sexual exploitation and abuse also occur more frequently. Programmes that integrate key actions in HIV/AIDS, as outlined in the guidelines of the Inter-Agency Standing Committee Task Force on HIV/AIDS in Emergency Settings, such as food security interventions, are effective means of preventing the spread of HIV.

IX. Migrant and mobile worker populations

17. It is the situations faced in migration, in particular poverty, exploitation, and separation from families and partners, that put migrants and mobile workers at risk

of HIV infection. There is an increasing awareness that migrants often live in situations where they are more vulnerable to HIV than local populations, and are at risk of spreading the infection upon their return in communities and countries of origin, often unwittingly. The heightened vulnerabilities of these populations to HIV must be addressed.

X. Continuum of prevention, treatment, care and support

18. Prevention, treatment, care and support efforts form a response continuum, including prevention by and for people living with HIV. The challenge of integrating prevention fully into treatment and care delivery must be met, as their effectiveness is vastly improved when they are utilized together. Without effective prevention, treatment will become increasingly unsustainable. It is essential to prioritize interventions with populations most at risk and to uphold the strategy of greater involvement of people living with HIV and AIDS, especially to ensure their full involvement in prevention efforts.

XI. Intensifying prevention

19. Low use of prevention interventions (for example less than 5 per cent among injecting drug users,[5] 5 per cent for prevention of mother-to-child transmission of HIV and 42 per cent for condoms)[6] reveals a critical coverage gap in the response. The fact that those most vulnerable to infection most often have no access to prevention should be a major cause for alarm. **Prevention is the best and most viable approach to reverse, and ultimately halt the epidemic and must remain the foundation of any response.** The same urgency that has been brought to bear on the drive to expand treatment access thus must also be brought to re-intensify HIV prevention. Key questions to consider include:

(a) **How can synergy between prevention, treatment and care be maximized? Integration of sexual and reproductive health and HIV/AIDS may be one important answer;**

(b) **What are the key issues to overcome in order to effectively engage multiple ministries and groups in the national response? For example, how can broad engagement in education be motivated?**

(c) **How can nations expect sustainable progress against the epidemic without addressing underlying structural issues, including ensuring human rights, gender equality, women's empowerment and poverty reduction?**

(d) **Given the innate sensitivities, how can national action plans be enhanced to better meet the needs of the most vulnerable and ensure that programmes address populations engaged in high-risk behaviours? For example, can public-private partnerships be formed to take effective action on drug abuse prevention and drug dependence treatment programmes?**

(e) **How can we ensure that the vulnerability and risk levels among young people are acknowledged, understood and overcome? Better age disaggregated data collection might provide a starting point. Furthermore, how**

can nations address young people's special needs and circumstances and respect their rights?

(f) **How can nations better ensure the full involvement of civil society, young people, women, at-risk populations and people living with HIV and AIDS at all stages of the response from planning and implementation to monitoring and evaluation?**

(g) **How can monitoring and evaluation systems and capacities be strengthened to provide a stronger evidence base and enhance results in HIV prevention?**

(h) **How can nations best scale up prevention efforts? Building on evidence, informed interventions with proven impact will be an essential element, including the use of positive socio-cultural values and norms that encourage an environment of non-discrimination and destigmatization to open the door to effective prevention and care efforts.**

20. There is increasing political commitment to fight HIV/AIDS within the world community, and funds are increasingly available. The synergies among prevention, care and treatment are understood, and there is a more clear understanding of effective and promising interventions. What is needed is a more rigorous upholding of the universality of human rights, including for young people, women and the most vulnerable populations, as well as greater action, building upon what works and linking existing infrastructures to ensure maximum coverage and impact.

Notes

[1] Global HIV Prevention Working Group. 2004, "*HIV Prevention In The Era Of Expanded Treatment Access*"

[2] United Nations Millennium Project, 2005, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*, and multiple task force reports presented in January 2005.

[3] The achievement of the goals and targets set out in the Declaration of Commitment on HIV/AIDS, adopted at the twenty-sixth special session of the General Assembly, contribute directly to the achievement of the Millennium Development Goals, particularly Goal 6: to halt and reverse the HIV/AIDS epidemic.

[4] United Nations Millennium Project, 2005, *Combating AIDS in the Developing World*, Task Force 5 on HIV/AIDS, Malaria, TB, Other Major Diseases and Access to Essential Medicines, Working Group on HIV/AIDS.

[5] The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children, 3-5 May 2004.

[6] As noted in the Programme of Action of the International Conference on Population and Development.

[7] Joint United Nations Programme on HIV/AIDS (UNAIDS), 2004, *2004 Report on the global AIDS epidemic*. While prevalence rates among women and men vary among and within regions, the overall trend of infections in women is cause for alarm.

[8] United Nations Office on Drugs and Crime.

[9] Global HIV Prevention Working Group. 2004, "HIV Prevention In The Era Of Expanded Treatment Access".